UROLOGY OF NORTH FLORIDA RADIATION ONCOLOGY OF NORTH FLORIDA CANCER CARE OF NORTH FLORIDA

NAME: ____ **TODAY'S DATE**: ____________________

Last First MI

SS #______________________________ **SEX:** M_____F_____ **DOB**:____/____/_____ **AGE:** ______________

ADDRESS:____

HOME PHONE ( ) _______________ **CELL PHONE ( )** ________________ **WORK PHONE ( )** ___________________

EMAIL ADDRESS____

MARTIAL STATUS: __________________ **SPOUSE'S NAME:** ______________________ **PHONE** ____________________

RACE ________________________________ **ETHNICITY** ______________ **PRIMARY LANGUAGE** _______________________

EMPLOYMENT STATUS □ Full time □ Part time □ Retired **OCCUPATION**____

EMPLOYER NAME____________________________________ **EMPLOYER PHONE ( )** __________________________

PRIMARY HEALTH INSURANCE **Primary Subscriber's SS# (if different than patient)** _______/_______/________

INSURANCE COMPANY_________________________ **SUBSCRIBER NAME**___________________ **DOB**_____/____/_____

ID NUMBER________________________**GROUP NUMBER**_________________**EFFECTIVE DATE**_____/______/_______

SECONDARY HEALTH INSURANCE **Subscriber's SS# (if different than patient)** _______/_______/________

INSURANCE COMPANY________________________ **SUBSCRIBER NAME**___________________ **DOB**_____/____/_____

ID NUMBER________________________**GROUP NUMBER**_________________**EFFECTIVE DATE**_____/______/_______

IS THE PATIENT A MINOR? _____YES _____NO

PARENT'S NAME: ____

PARENT'S HOME ADDRESS:____

HOME PHONE ( ) _______________ **CELL PHONE ( )** ________________ **WORK PHONE ( )** _________________

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME ____ **RELATIONSHIP**____

HOME PHONE ( ) ______________ **CELL PHONE ( )** _______________ **WORK PHONE ( )** ___________________

SECONDARY CONTACT___________________________ **RELATIONSHIP**____

HOME PHONE ( ) ______________ **CELL PHONE ( )** _______________ **WORK PHONE ( )** ___________________

HAVE YOU COMPLETED ANY ADVANCED DIRECTIVES? _____YES _____NO

(If YES, check all that apply) _____ Living Will ____ DNR ____ Durable Power of Attorney

(If NO) Do you wish to learn more about Advance Directives? _____YES _____NO

Urology
289 SW Stonegate Terrace
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Fax: 386.719.3856

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Phone: 386.755.1655
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Radiation Oncology
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UROLOGY OF NORTH FLORIDA | RADIATION ONCOLOGY OF NORTH FLORIDA | CANCER CARE OF NORTH FLORIDA

What Doctor referred you to our facility? ____
Who is you Primary Doctor? ____
Do you live in a Skilled Nursing Facility? No____ Yes____ Facility Name: ________________________________
Do you have Hospice Care? No____ Yes____ Facility Name: ____
Do you live alone? Yes_____ No_____

Why are you here to see us today? ____
Do you have or have had any of the following:

□ Heart Disease	□ Stomach Ulcer	□ Bipolar Disorder
□ Heart Murmur	□ Liver Disease	□ Anxiety
□ Heart Arrhythmia/A-fib	□ Jaundice	□ Depression
□ Heart Pacemaker/Defibrillator	□ Measles	□ Frequent Headaches
□ Lung Disease	□ Mumps	□ Glaucoma
□ Heart Attack/Failure	□ Chicken Pox	□ Bleeding Disorder
□ Stroke	□ Anemia	□ Shingles
□ TIA	□ Rheumatic Fever	□ Mitral Valve Prolapse
□ Angina	□ Sickle Cell Disease	□ Osteoporosis
□ High Blood Pressure	□ Thyroid/Parathyroid Disease	□ Gastroesophageal Reflux Disease (GERD)
□ High Cholesterol	□ Stomach/Intestinal Disease	□ Diabetes: Type_________
□ Artificial Heart Valve	□ Pneumonia (Recurring)	□ Hypoglycemia (Low Blood Sugar)
□ Congenital Heart Disorder	□ Kidney Disease	□ Emphysema/COPD
□ Faint Spells/Dizziness	□ Renal Dialysis	□ Hives
□ Artificial Joint	□ Bronchitis (Recurring)	□ Asthma
□ Blood Disease/Leukemia	□ Sexually Transmitted Disease	□ Tuberculosis
□ Blood Transfusion	□ AIDS/HIV Positive	□ Valley Fever
□ Bruise Easily	□ Hemophilia	□ Chronic Urinary Tract Infections
□ Cancer: Type_____________	□ Alzheimer's Disease	□ Scarlet Fever
□ Chemotherapy/Immunotherapy	□ Parkinson's Disease	□ Hepatitis: A/B/C
□ Radiation Therapy	□ Feeding Tube	□ Blood Clots
□ Epilepsy or Seizures		

Have you ever had any serious illness not listed above?

____
____
____

PREVIOUS SURGERIES/HOSPITALIZATIONS **DATE**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

MALE SCREENINGS	**DATE**
Last PSA blood test	__________
Last prostate digital rectal exam	__________
Last colonoscopy	__________

FEMALE HISTORY/SCREENINGS

Have you ever been pregnant	_____YES	_____NO
Number of Pregnancies	__________	
Number of Births	__________	
Age at First Birth	__________	
Age of Last Birth	__________	
First day of last menses	__________	
Age of Menopause	__________	
Date of last colonoscopy	__________	
Last mammogram	__________	
Last PAP smear	__________	

Have you ever taken birth control hormone?	YES	NO	If YES, number of years taken_________
Have you ever taken fertility medication?	YES	NO	If YES, number of years taken_________
Have you ever had anti-hormonal therapy?	YES	NO	

SOCIAL HISTORY			**TYPE**	**FREQUENCY**
Do you drink alcoholic beverages?	YES	NO	_______________	____________________
Do you use recreational drugs?	YES	NO	_______________	____________________
Do you drink caffeinated beverages?	YES	NO	_______________	____________________

Do you currently use tobacco products? YES NO _______________ ____________________
Have you ever used tobacco products? YES NO _______________ ____________________
(If yes) What age did you start? ______ What age did you stop? _______
Current/Former occupation: _________________________________ Are you retired? __________

Marital Status: ____Single ____Married ____Divorced ____Widowed

PLEASE LIST ALL ALLERGIES:

NAME	REACTION

MEDICATIONS____

Preferred Pharmacy: _______________________________**City:**_____________________**Phone:**___________________

DRUG	DOSE	FREQUENCY	START DATE	COMMENTS

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY HAD HEREDITARY CANCER GENETIC TESTING?
_____YES _____NO _____DON'T KNOW

IF YES, DO YOU HAVE ACCESS TO THE RESULTS? _____YES _____NO _____DON'T KNOW

TYPE OF GENETIC TESTING? ____

PLEASE LIST ANY BLOOD RELATIVES THAT HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES:

Relation	**Whose Side** Paternal/Maternal	**Status** Alive/Deceased	**Age at Diagnosis**	**Current Age**	**Cancer (List Type)**	**High Blood Pressure**	**Heart Attack**	**Stroke**	**Diabetes**

ANY ADDITIONAL BLOOD RELATIVES WITH DISEASES NOT LISTED?
____
____
____
____

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REVIEW OF SYSTEMS – CHECK ALL THAT APPLY

	GENERAL		GENITOURINARY		FEMALE BREAST/REPRODUCTIVE
	Fatigue level (0 – 10) ________		Pain and/or burning with urination		Do you perform self breast exams?
	Appetite _____ Good _____ Fair _____ Poor		Blood in urine		Breast masses/sores/lumps/nodules
	Total weight loss in last 6 months ________ pounds		Problems starting, maintaining, completing urine flow		Nipple discharge
	Fevers / chills / night sweats		Urinary incontinence/leakage		Nipple inversion
	NEUROLOGICAL		Urinary frequency and/or urgency		Breast pain
	Headaches		Frequent urination at night		Vaginal sores/nodules/lumps
	Vertigo (dizziness)		**GASTROINTESTINAL**		Irregular vaginal bleeding/discharge
	Syncope (fainting)		Constipation		Pain with intercourse
	Ataxia (lack of coordination)		Diarrhea		Heavy menstrual bleeding
	Changes in speech		Nausea and/or vomiting		**MALE REPRODUCTIVE**
	Change in memory/concentration		Acid reflux		Erectile dysfunction
	Confusion		Blood in vomit		Mass, lump, or pain in testicles
	CARDIOVASCULAR		Blood in stool		Curvature of the penis
	Irregular heartbeat		Abdominal pain		Pain with intercourse
	Chest pain / Palpitations		**EYES**		**MUSCULOSKELETAL**
	Swelling		Blurred Vision		Weakness
	Pacemaker/Defibrillator		Excessive eye watering		Numbness
	RESPIRATORY		Visual difficulties		Bone pain
	Shortness of breath		**EARS NOSE THROAT**		Recent falls
	Cough		Hearing loss: (Circle) R L Both		Use of assistive device Type:
	Hemoptysis (Coughing up blood)		Ear pain		**INTEGUMENTARY**
	Asthma		Ringing in ears		Jaundice
	Trouble breathing while lying flat		Sinus drainage		Edema/Swelling
	Do you use Oxygen?		Nose bleeds		Skin rashes/Itching
	ENDOCRINE		Sores on tongue or gums		Wound/Sore
	Hot flashes		Difficulty swallowing		Nodules/Lumps
	HEMATOLOGIC		Altered taste		Healing incision
	Anemia		Hoarseness or change in voice		Vascular Access Type: Location____________
	Blood clots		Lumps in neck		**PSYCOLOGIC**
	Abnormal bruising		**IMMUNOLOGIC**		Depression/Sadness
	Low blood counts		Frequent colds		Anxiety
	Blood transfusions		Outdoor allergies		Trouble sleeping
			Cold sores		Thoughts of suicide
			Serious infections		Frequent mood swings
			Autoimmune disorder Type:		
			Sepsis		

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OTHER SYMPTOMS/CONCERNS:

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be
dangerous to my (or patient's) health. It is my responsibility to inform the physician's office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________________ **DATE** ______________

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Medical Records Release

Patient Name: ____ Date of Birth: _____________

Social Security No.____

I hereby authorize Cancer Care of North Florida to release or obtain any medical information and records concerning my treatment to my physicians and medical providers and any third-party carrier (insurance company or government agency) when requested for its use in connection with making or determining claim for such treatment and/or diagnosis.

Please release requested records:
____
____
____
____

The undersigned authorizes the release of records pertaining to:

1. Testing and/or treatment of AIDS and AIDS related disease YES_____ NO_____
2. Treatment for psychiatric illness YES_____NO_____
3. Treatment for drug and/or alcohol abuse YES_____NO_____

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing.

Signature of patient / representative____

Address: ____
City: ____
Phone: ____
Name and relationship if other than self: ____

Office use only: Date received: _____________ Date sent: ____________ By: __________________________

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Authorization to Release Records to Family/Friends

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

YES NO

May we leave a detailed message on your answering machine at home or on your cell phone?

YES NO

May we discuss your medical condition with members of your family?

YES NO

If YES, please name all members ALLOWED to receive communication regarding your medical condition and billing information:

Name	Relationship

This consent was signed by (PRINT NAME): ____

Signature: ____ Date: ________________

Witness: ____ Date: ________________

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Consent for Health Information Exchange (HIE)

I grant permission, to download and exchange medical information about me – including but not limited to past and current medications, lab and x-ray test results, hospitalizations, and visits to other providers participating in such exchanges – to ensure that my medical history is complete and accurate. I understand, they may only disclose my protected health information (PHI) according to federal and state laws and the separate authorization to use and disclose PHI.

____ ______________________
Patient's Signature or Signature of Patient's Representative Date

____ ______________________
Printed Name of Patient's Representative Relationship to Patient

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Lake City Cancer Care, LLC

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I agree to assign payment from my insurance companies for claims sent by **Lake City Cancer Care, LLC** for any medical treatment rendered to me. If payment is mailed to me for claims submitted by Lake City Cancer Care, LLC, I will forward payment immediately. I also understand that if I have Medicare coverage, I will be responsible for payment of the portion not covered by Medicare if I do not have secondary coverage. I agree that should the amount of insurance benefits be insufficient to cover my expenses, I will be responsible for the difference. Statements are payable at time of receipt unless prior arrangements have been made.

Please print your name here

Signature

____
Date

GENERAL CONSENT TO CARE

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to medical care (including disclosing my history, having a physical examination performed upon me, diagnostic testing, and treatment with medication or minor surgery), as ordered by a provider, while such medical care and treatment is provided through Cancer Care of North Florida, Urology of North Florida, and Radiation Oncology of North Florida on an outpatient/office visit basis. This consent includes my consent for all medical services rendered under the specific instructions of the provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. This consent extends to all Cancer Care of North Florida, Urology of North Florida, and Radiation Oncology of North Florida providers. **I understand**, that this consent is continuing in nature – even after diagnosis has been made or treatment begun.

____

Signature of Patient Date

Signature of Legally Authorized Representative: ____

Relationship of Legally Authorized Representative: ____

Date: ___________________________________

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Lake City Cancer Care, LLC

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: ____

Patient's Date of Birth: ________________________ Patient's SSN: _______________________________

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purpose of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

I, ____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

____ _______________________

Patient's Signature or Signature of Patient's Representative Date

____ _______________________

Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows: Name: Don Haaksma

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Electronic Mail User Authorization Form Patient Portal

The patient Portal offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal records: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this Electronic Mail User Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

TERMS

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this Electronic Mail User Authorization Form. Please write legibly. I Do Not Wish to Participate in the Patient Portal

☐ I Do Not Wish to Participate in the Patient Portal

____
Patient Name
(First name, Middle Initial, Last Name)

____
Email Address of Patient or Authorized

____
Date of Birth of Patient

____
Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

____
Patient's Designee's Name (Printed)

____
Patient's Designee's Signature

____
Patient's Signature

____
Date

____
Signature of Practice Staff

____
Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e, the Patient's Designated User) understands and agrees to use the listed email address for this phone.

CANCER CARE OF NORTH FLORIDA   UROLOGY OF NORTH FLORIDA   RADIATION ONCOLOGY OF NORTH FLORIDA

Patient Health Questionnaire (PHQ 2 & 9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Circle your best answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

TOTAL SCORE OF ABOVE 2 QUESTIONS ____________

If your total score is 3 or greater, please continue to the next set of questions. If your score is 3 or less, you may stop here.

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Circle your best answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

TOTAL SCORE OF ABOVE 9 QUESTIONS ____________

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